Procedures. PA requests for medically necessary dentures, pre-transplant dental services and orthodontia services may be submitted via mail, fax or telephone. PA is not necessary in emergency circumstances.

Written dental PA requests must be accompanied by:

1. Referral from member's physician/dentist substantiating medical necessity of services through description of medical condition

2. Dentist's treatment plan and schedule, and

3. Radiographs fully depicting existing teeth and associated structures by standard illumination when appropriate.

- **DIALYSIS**

Description. AHCCCS covers dialysis and related services furnished to AHCCCS FFS members by qualified providers without PA.

Refer to Chapter 300, Policy 310, for covered dialysis services for members not in FESP.

Refer to Chapter 1100 for information regarding FESP dialysis services.

- **EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES**

Description. EPSDT services provide comprehensive health care, as defined in 9 A.A.C. 22, Article 2, through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening. Limitations and exclusion, other than the requirement for medical necessity, do no apply to EPSDT services.

PA for these services is only required as is designated in this policy and in Chapter 400, Policy 430.

Refer to Chapter 400, Policy 430, for complete information regarding EPDST services (overview, definitions, screening requirements, service standards, provider requirements and exhibits).

- **EMERGENCY MEDICAL SERVICES**

Description. A provider is not required to obtain PA for emergency medical services; however, a provider must comply with the notification requirements in 9 A.A.C., Article 2.

Notification of emergency admissions may be submitted via fax or telephone. A provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

Refer to Chapter 300, Policy 310 and Exhibit 310-1, for review of the Rule sections regarding FFS emergency services.

Refer to Chapter 1100 for information regarding the Federal Emergency Services Program.

- **EYE CARE/OPTOMETRY SERVICES**

Description. AHCCCS covers eye care/optometric services for members, within limitations. Coverage is provided as described in Chapter 300, Policy 310.

1. Emergency eye care services do not require AHCCCS authorization.

2. Eye examinations and prescriptive lenses are covered only for EPSDT and KidsCare members. PA is not required. Prescriptive lenses for members age 21 and older are not covered unless they are the sole visual prosthetic device used by the member after cataract removal surgery.

3. Cataract removal requires PA from the AHCCCS/DFSM/PA Unit. Children needing cataract removal should be referred to Children's Rehabilitative Services. Other prior authorization requests for cataract removal services may be submitted via mail, fax or telephone.

- **FAMILY PLANNING SERVICES EXTENSION PROGRAM**

  Description. AHCCCS covers comprehensive family planning services through the Family Planning Services Extension Program for SOBRA women whose eligibility has terminated, who are not eligible for any other AHCCCS services, and who voluntarily choose to delay or prevent pregnancy. These services may be provided for up to 24 months following date of delivery. Any medical service not included in the Family Planning Services Extension Program is not covered.

  Refer to Chapter 400, Policy 420 for a complete discussion of the Family Planning Services Extension Program.

- **HOME HEALTH**

  Description. All home health services require PA from the AHCCCS/DFSM/PA Unit.

  Refer to Chapter 300, Policy 310, for complete information regarding covered home health services.

  Procedures. PA requests for home health services should be submitted by mail, fax, or telephone prior to providing services.

- **HOSPITAL INPATIENT SERVICE AUTHORIZATION**

Description.

Hospital inpatient service authorization is a part of the utilization management process that may consist of both PA and continued authorization, contingent upon concurrent review findings (refer to Policy 810).

Procedures.

Initial Service Authorization:

Under 9 A.A.C. 22, Article 2, the provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

1. Providers must obtain PA from the AHCCCS Administration for the following inpatient hospital services:

    a. Organ and tissue transplantations (this authorization review is performed by the AHCCCS Transplant Coordinator with the exception of corneal transplants that are submitted to the AHCCCS/DFSM.PA Unit.)

    b. Non-emergency admissions, including psychiatric hospitalizations

    c. Elective surgery, excluding a voluntary sterilization procedure, and

    d. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.

2. Women and their newborns may receive up to 48 hours of inpatient hospital care after a normal vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay.

3. For retrospectively eligible members, notification requirements are as follows:

   a. When the member is made eligible while still in the hospital, providers must notify the Administration no later than 72 hours after the eligibility posting date for emergency hospitalizations.

   b. When eligibility is posted after the member is discharged from the hospital, the notification requirement in 3(a) will be waived.

4. Payment for services may be denied if the hospital fails to provide timely notification or obtain the required authorization number(s) within the parameters specified in this policy. However, the issuance of an authorization number does not guarantee payment; documentation provided from the member's medical record must support the diagnosis for which the authorization was issued, and the claim must meet clean claims submission requirements.

   Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding pre-payment review criteria and submission requirements. This manual is available online at the AHCCCS Web site.

5. Authorization may be provisional if further review of information or documentation is needed to make a full assessment of the medical necessity for the admission, the service(s), and/or to determine the appropriate length of stay. This information may be obtained through on-site or telephonic concurrent review. Upon approval or denial, the provisional status is removed from the authorization and the provider is notified by letter of the decision.

- **HYSTERECTOMY**

Description. Hysterectomy services require prior authorization (PA) from the AHCCCS./DFSM/PA Unit.

Refer to Chapter 300, Policy 310, for complete information regarding covered hysterectomy services.

Procedures. PA requests for hysterectomy services may be submitted via mail, fax or telephone.

The medical record must document the medical necessity of the hysterectomy, including prior medical and surgical therapy and results. Also, the member must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. PA may be granted based on these documents. Providers may use the sample AHCCCS hysterectomy consent form contained in this Chapter, Exhibit 820-1, or they may use other formats as long as the forms include the same information and signatures as the AHCCCS hysterectomy consent form.

The provider is not required to complete a consent to sterilization form prior to performing hysterectomy procedures and the 30-day waiting period required for sterilization does not apply to hysterectomy procedures.

In a life-threatening emergency, authorization is not required, but the physician must certify in writing that an emergency existed.